

**Remarks of C. Richard Dwozan
President, Habersham County Medical Center
and
Chairman, Georgia Hospital Association
prepared for
Study Commission on the Efficacy of Georgia's
Certificate-of-Need System
August 8, 2005**

I. INTRODUCTION

Good afternoon ladies and gentleman. I'm Dick Dwozan, Chairman of the Georgia Hospital Association Board of Trustees and President of Habersham County Medical Center, a 53 bed acute care hospital located in Demorest, Georgia. On behalf of GHA, I am grateful for the opportunity to provide you with a broad overview of the essential and productive role played by the Georgia Certificate of Need Program. We believe that the charge given to this Commission by the Legislature is extremely important, and we are pleased that by setting out a two year time frame for you to complete your work, the legislature has given you sufficient time to conduct an in-depth study on the numerous and complex facets and implications of the Certificate of Need Program. I hope that in my presentation today, and in future meetings, GHA can be of valuable service to the Commission in providing information and articulating the benefits and the necessity of a strong CON Program.

Kurt Stuenkel has spoken to you about the important role this Program plays in controlling costs and ensuring quality health care services. In addition, there are many other implications to the health care delivery system which GHA believes should be considered by the

Commission in the course of its study, including the interplay between the CON Program and access to care, indigent and charity care, emergency and trauma care, physician self-referral, long-term care and the current financial condition of Georgia's hospitals. While I will touch on several of these issues in my remarks today, Georgia's hospital community urges you to focus in greater depth on each area. We respectfully request you consider making each of these issues a focus of one of your meetings over the next two years, since the CON program, and any discussion of its revision, will significantly impact all of these topics.

Let me begin by providing you with a little background on GHA. The Georgia Hospital Association is a non-profit trade association representing approximately 170 hospitals throughout Georgia. Our membership includes Georgia's rural, urban, non-for profit and for-profit hospitals alike. GHA's purpose is to promote the health and welfare of the public through the development of better hospital care for all of Georgia citizens. Our vision is straightforward: Georgia hospitals and health systems will serve the health needs of all Georgians through a full range of quality services in a cost effective, coordinated manner.

I am here today representing not only the Governing Boards and administrative staffs of GHA's member hospitals, but more importantly the hundreds of thousands of individuals who work at our hospitals, our medical staffs, nurses, allied practitioners, and the numerous categories of support personnel who allow our hospitals to function. These caregivers rely on our hospitals to provide quality settings in which they can perform their skilled professions. They also rely on the financial viability of the hospitals to earn an income to support themselves and their families. I would like to point out that many physicians in this State recognize and appreciate how essential a viable hospital system is to their practices and to patient care, and do

not want to see the viability of that system jeopardized. I hope the Commission will have an opportunity to hear from these physicians directly.

I am also here representing all Georgia citizens; to the extent we share a common interest in ensuring the availability of trauma services should we or our loved ones require them. Finally, I am here representing the interests of the indigents in our state, the Medicaid population and millions of uninsured Georgians. Georgia hospitals are the health care safety net essential to ensure that these individuals have access to health care services. GHA's membership believes it is critically important for this Commission to understand the relationship between the continued viability of the already fragile safety net and a strong CON Program.

A central component of this discussion relates to the current health care reimbursement system. There are many essential health care services for which payors do not reimburse at a level that even comes close to covering the costs of providing such services. For example, Medicaid rates for hospital outpatient services are set at 85.6% of cost, not charges, but cost. Inpatient services are reimbursed by Medicaid at 80% of costs. Uninsured and indigent Georgians come to the hospitals' emergency rooms and outpatient clinics for care. Many can pay little if anything for the care they receive. The only way for hospitals to provide these services is to subsidize them with the profits received for well-reimbursed services. Any weakening of Georgia's CON Program would limit these essential subsidies.

As we know from the experience in non-CON states, the only "competition" that occurs when states abandon their CON Programs is for highly reimbursed services. I urge you to keep in mind as you consider the testimony of those who would abolish our CON Program, that none of them desire to compete with hospitals to provide trauma or emergency services or to provide services to Medicaid recipients, the indigent or the uninsured. In fact, as the binder provided to

you today illustrates, study and after study has found that states which abandon their CON Programs see a proliferation of physician owned surgery centers and specialty hospitals that provide only the most profitable services, do not provide emergency services, serve few Medicaid and indigent patients and essentially function to redirect the most profitable services out of the full-service community hospitals. This leaves full service hospitals with insufficient revenues to subsidize the essential but unprofitable service needs of their communities. Perhaps these facts help to explain why I can unequivocally state that GHA's membership is unanimous in its support of a strong CON Program in Georgia. They certainly help explain why many states that have curtailed or eliminated CON are trying to bring it back or have substituted restrictive regulations to control development of health care facilities and services.

My hospital, Habersham County Medical Center, is the sole community provider in Habersham County and we also serve patients from adjacent counties in this predominately rural area of north Georgia. Our services include nursing home beds and a broad range of medical and surgical care, including inpatient care; imaging; general and specialty surgery, both inpatient and outpatient; our family birth center; ICU; an active emergency room. We treat all patients who present irrespective of their ability to pay, including indigents, Medicaid recipients and Medicare and privately insured patients.

I believe it's instructive in the consideration of the future of the CON Program in Georgia to consider what health care in Habersham County, for example, would look like if our hospital could not support itself. On the one hand, I think it's fair to say that there would be physicians and potentially other proprietary investors willing to develop free standing centers to pick up the performance of outpatient surgery and the provision of imaging services for well insured patients. There might even be some physicians or a national proprietary organization willing to

develop an orthopedic specialty hospital, or even a cardiovascular services hospital, but that's about it. The provision of the balance of services that Habersham County Medical Center now provides would fall on our local government, or, more likely, the state government, because if our hospital were to close or reduce unprofitable services, chances are good that the surrounding hospitals would have already, or would shortly, suffer the same fate. The financial burden on the government, local or state, would be enormous.

To the hospitals represented by GHA, that's what the discussion of Certificate of Need boils down to: does a strong CON Program enhance the ability of hospitals in Georgia to sustain the provision of essential health care services and enhance the accessibility of those services to all of our population, irrespective of ability to pay? Every hospital member of GHA emphatically believes that Georgia's CON Program does serve this purpose.

II. CON PURPOSE

GHA believes that the CON Program remains true to its original purpose: to insure that health care services are developed in an orderly and economical manner so as to be available to all citizens. Health care services and facilities should be provided in a manner that avoids unnecessary duplication of services, is cost effective, and is compatible with the health care needs of the various areas and population of the state.

As discussed at the first meeting, CON programs were initiated in each state in the late '70s pursuant to federal mandate premised on the calculation of Medicare reimbursement on a capital cost basis. If Medicare was going to pay based on what was spent, it certainly made sense to subject expenditures to an assessment of need. It has been suggested that changes in the

reimbursement system have eliminated the need for CON programs. Nothing could be farther from the truth. Reimbursement changes actually necessitate the continuance of a strong CON Program in Georgia.

The government no longer pays for services based on costs. Instead, Medicare now pays a flat rate for a specific type of service, regardless of the amount of resources it takes to provide that service to an individual patient. This system assumes a typical hospital will serve a balance of less sick and sicker patients with similar conditions. In CON states, including Georgia, this is generally a fair assumption. However, when states abolish CON and physician-owned facilities spring up, that assumption no longer holds true. To understand why, one must recognize that physicians control where they refer individual patients. Numerous studies have concluded that physician's who own surgical hospitals refer the healthiest patients to their own facilities and refer sicker patients to the full-service community hospitals. This cherry-picking of healthier patients results in higher profits for the physician owners because limited service specialty hospitals receive the same flat rate payment for treating patients who are overall much less sick, and therefore cost less to treat. The profits at the full service community hospitals drop, because the balance of more sick and less sick patients is lost. They are left to treat consistently sicker patients, which increases their costs without any corresponding increase in the flat rate payment.

Likewise, the CON Program continues to serve the function of reducing over-utilization of services. Numerous research studies demonstrate that financial incentives linked to physician-ownership cause physicians to change their practice patterns. Simply put, physician owners order more services and procedures when they did before they obtained an ownership interest because they have a financial incentive to do so.

Although you may hear arguments to the contrary, the prevailing wisdom is that in the health care arena, increasing supply without consideration of need does not result in higher quality or lower cost due to increased competition. The result, rather, is increased utilization of profitable services with no corresponding benefit to the balance of the health care delivery system in terms of cost, quality, or access.

As will be apparent from the presentations of the interests of certain physicians represented by the Medical Association of Georgia, and the Georgia Society of Ambulatory Surgery Centers, an immediate result of elimination or curtailment of our CON Program will be the proliferation of physician owned ambulatory surgery centers, imaging centers, and specialty hospitals such as orthopedic centers or cardiovascular centers. These facilities will not be developed because these services are not currently available and accessible. They will be developed solely because some physicians want to make more money. They will accomplish this by directing their patients to facilities in which they have an ownership interest. This will allow them to receive payments not only for their physician services, but also, as an owner, to receive profits from the facility fee as well. I note that simply opening the doors of an imaging center, ambulatory surgery center, or specialty hospital does not necessarily dictate that it will be profitable. To ensure profitability, you have to be selective as to which patients are treated there. Since the owning physicians will control the referrals, it follows that they will refer healthier, fully insured patients rather than sicker, indigent and Medicaid patients – that's simply good business, and good business is what these facilities will be about.

Hospitals will be presented, to an even greater extent than they are currently, with the significant erosion of their revenue stream due to the loss of paying patients for these highly reimbursed services such as imaging and outpatient surgery. This undermines the ability of

hospitals to continue to provide essential services such as emergency room, intensive care, trauma and other intense inpatient services. The eventual result is the bankrupt hospital system described in my earlier scenario, in which, as I indicated, the provision of essential, safety net hospital services would fall to the government.

It is important also to note that in addition to protecting revenues needed to subsidize essential under-funded services, the CON Program in Georgia directly ensures accessibility to health care services for poor Georgians by requiring an applicant to commit a specific amount of clinical health services to indigent and charity patients. The CON rules state this indigent care commitment as a certain percentage, usually 3%, of an entity's adjusted gross revenues. Each year, DCH evaluates whether facilities satisfied their commitments and imposes dollar for dollar fines for any shortfall. These fines go into the Indigent Care Trust Fund to help offset the costs of providing indigent care. The opponents of Georgia's CON Program should be required to articulate how they plan to help the state replace the tens of millions of dollars in indigent care services generated by this component of the CON Program.

This issue is more critical now than ever before given the changes to the Medicaid program that are in various stages of implementation. Changes such as implementation of Medicaid managed care; disease management for the aged, blind and disabled population; the uncertain future of Upper Payment Limit (UPL) funding; changes to the Indigent Care Trust Fund allocations; changes in the outpatient reimbursement methodology; possible changes in the ability of restructured hospital authority hospitals to make intergovernmental transfers; the federal government's interpretation regarding the permissibility of a tax on Medicaid CMOs; and, yearly cuts in the Medicaid budget, all combine to create an atmosphere in which hospitals are anxious about how these changes will impact their ability to provide health care services to

all the citizens of Georgia. In light of this uncertainty, any weakening of the current CON Program should be viewed by the state with greater than usual skepticism.

III. SUMMARY

In conclusion, we again urge the Commission to carefully and methodically explore the relationship between Georgia's CON Program and access to care, indigent and charity care, emergency and trauma care, physician self-referral, and long-term care and the current financial condition of Georgia's hospitals. GHA believes that only after these and any other relevant issues have been analyzed will it be appropriate, and true to the Commission's charge, to assess whether there are beneficial changes to be considered. Some of the revisions which have been discussed already, such as the streamlining the CON appeals process, should have broad acceptance and we would be pleased to be involved in that discussion.

In addition, we strongly assert that to the extent that this Commission is urged to address concerns about alleged hospital operational issues or abuses, it is not the answer to promote unfettered competition from referring physicians, or even from other hospitals. To do so would prove destructive to our health care delivery system. Our membership is in total agreement on that.

Thank you for your time and attention. I'll be pleased to respond to any questions you may have.